

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06579  
Reg. Dist. No. **302**

6593

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>834 W. Washington Street</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Thomas</u> Middle <u>Louis</u> Last <u>Baum</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>17</u> Year <u>19 56</u>			
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Aug. 23, 1954</u>			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>9. AGE</b> (In years last birthday) <u>1</u> yrs.		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Child</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hagerstown, Maryland</u>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>				<b>13. FATHER'S NAME</b> <u>Elmer L. Baum</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Helen Snapp</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT</b> Address <u>Mr. Elmer L. Baum - 834 W. Wash St.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <u>Poisoning Due to ingestion of Polish Remover</u>            DUE TO <u>Anoxia</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            (b) _____            DUE TO _____            (c) _____         </div> <div style="width: 15%; text-align: center;">           INTERVAL BETWEEN ONSET AND DEATH  <u>36 hrs.</u> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <u>None</u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Drank Polish Remover</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>3</u> Minute <u>XX</u> <u>June 15</u> <u>19 56</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>at home</u>			
<b>20f. (City or town)</b> <u>Hagerstown</u>		<b>(County)</b> <u>Wash.</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u> <b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <u>6-18-56</u> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-19-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Hagerstown, Maryland</u>		<b>(State)</b>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>			<b>ADDRESS</b> <u>Hagerstown, Md.</u>				
<b>24a. REC'D BY REGISTRAR</b> <u>June 20, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Bowers</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.  
 VS. A15ME(S)  
 SM 9/55

03

81

21

2

BP

**BUREAU V. S.**

JUN 22 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Dr. Wells	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										06580	
										Reg. Dist. No. 302	
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Domenici Tire Co.</u>					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1019 Virginia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Byer</u> Last <u>Beckley</u>					4. DATE OF DEATH Month <u>June</u> Day <u>25</u> Year <u>1956</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Domenici Tire Co</u>				11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>David Byer Beckley</u>					14. MOTHER'S MAIDEN NAME <u>Louise Byer</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>			16. SOCIAL SECURITY NO. <u>no</u>			17. INFORMANT <u>Mrs. Effie Byer</u> Address <u>1019 Virginia Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>( Report // will be forwarded after 260X )</u> DUE TO <u>autopsy analysis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary heart disease</u> DUE TO <u>Diabetes M - uncontrolled</u> (c) <u>  </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>None</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>6/27/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown, Md.</u>						24. REC'D BY REGISTRAR <u>June 28, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Bowers</u>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JUL 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

06581

Reg. Dist. No. 302

6595

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		d. STREET ADDRESS <b>245 Winter St.,</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Victor</b> Last <b>Bloyer</b>		4. DATE OF DEATH Month <b>6</b> Day <b>1</b> Year <b>19 56</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1910</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>G.M.Gehr &amp; Son</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James C. Bloyer</b>		14. MOTHER'S MAIDEN NAME <b>Nora Holbert</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-6343</b>	
17. INFORMANT <b>Mrs. Grace Bloyer</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>443x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSION.</b> DUE TO (c) <b>ARTERIOSCLEROSIS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>4 RS.</b> <b>4 RS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. 11.</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAY</b> 19 <b>56</b> , to <b>june 1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>JUNE 1</b> , 19 <b>56</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis G. Graf</b> M.D.		ADDRESS (Street, city or town, state) <b>119 E. Antietam</b> DATE SIGNED <b>6-1-56</b>	
PHYSICIAN'S NAME (Type) <b>Louis G. Graf M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-5-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown rural Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24. REC'D BY REGISTRAR <b>June 6, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>East Hovers</b>	

CHIEF OF POLICE



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 6631 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

66582  
301

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
c. LENGTH OF STAY IN 1b <u>3 yrs.</u>				d. STREET ADDRESS <u>13 N. Conococheague</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHNATHAN PETER BOWSER</u>				4. DATE OF DEATH Month Day Year <u>June 18, 1956</u>			
5. SEX <u>male</u>		6. COLOR OF RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 19, 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR: Months <u>0</u> Days <u>29</u>		IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>29</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postal CLERK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>Williamsport, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>WILLIAM OSCAR BOWSER</u>				14. MOTHER'S MAIDEN NAME <u>HANNAH ARDINGER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT Address <u>Williamsport, Md.</u> <u>Mrs. Katherine Poffenberger</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>331X</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkeusson's Disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 18, 1956</u> to <u>June 18, 1956</u> that I last saw the deceased alive on <u>June 18, 1956</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul Haak</u> M.D.				DATE SIGNED <u>June 18, 1956</u>			
PHYSICIAN'S NAME (Type) <u>PAUL HAAK M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 20, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>RIVERVIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WILLIAMSPORT, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf Williamsport, Md.</u>				24a. REC'D BY REGISTRAR <u>6 Lee McElroy</u>		24b. REGISTRAR'S SIGNATURE	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6596

## CERTIFICATE OF DEATH

Reg. Dist. No.

06583

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>20 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eckstine Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Maurice</b> Last <b>Brown</b>			4. DATE OF DEATH Month <b>June</b> Day <b>14</b> Year <b>19 56</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1894</b>		9. AGE (In years last birthday) yrs. <b>62</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Conditioning</b>		11. BIRTHPLACE (State or foreign country) <b>Westville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Brown</b>				14. MOTHER'S MAIDEN NAME <b>Emma Crockett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>265-05-524</b>		17. INFORMANT Address <b>Mrs. John M. Brown Eckstine Ave. Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Choleliths, Chronic</b> DUE TO (c) <b>Thrombosis Aorta</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs.</b> <b>years.</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Aug 21, 1956</b> to <b>June 14, 1956</b> , that I last saw the deceased alive on <b>June 14, 1956</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Mirshman</b>				ADDRESS (Street, city or town, state) <b>154 W. Washington St. Hagerstown, Md.</b>			
DATE SIGNED <b>6/10/56</b>							
PHYSICIAN'S NAME (Type) <b>Philip J. Mirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 18, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>June 18, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G199 6-28-56 et

06584

Dr. Lusby

6597

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>839 Jefferson St.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ERNEST WILBUR BYER</u>				4. DATE OF DEATH Month Day Year <u>June 17, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1873 Aug. 24, 1873</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic W. Md. RR-Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Waynesboro, Penna.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>John Byer</u>				14. MOTHER'S MAIDEN NAME <u>Susan Stoner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-10-5521</u>		17. INFORMANT <u>Miss Mary Byer</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with Myocardial Failure</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage into S-tract - exact source not known</u> DUE TO <u>7 don</u> (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>10 hr +</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>11 hr</u> , 19 <u>56</u> , to <u>17 Jun</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>16 Jun</u> , 19 <u>56</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				M.D. _____			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby, M.D.</u>				<u>230 North Potomac St.-Hagerstown</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>June 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		65		M		W		JUN 22 1956		BALTIMORE, MARYLAND	
MARRIAGE		DATE OF MARRIAGE		PLACE OF MARRIAGE		NAME OF SPOUSE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIED		JAN 15 1910		BALTIMORE, MARYLAND		MARY H. HARRIS		JUN 15 1891		BALTIMORE, MARYLAND	
EDUCATION		SCHOOLING		OCCUPATION		HABIT		RELIGION		CAUSE OF DEATH	
HIGH SCHOOL		12		LABORER		SMOKER		METHODIST		HEART DISEASE	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL	
NONE		JUN 20 1956		JUN 22 1956		BALTIMORE, MARYLAND		DR. J. H. HARRIS		BALTIMORE, MARYLAND	
MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF CORoner	
NATURAL		JUN 22 1956		BALTIMORE, MARYLAND		DR. J. H. HARRIS		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF PHYSICIAN		NAME OF HOSPITAL		NAME OF CORoner	
J. H. HARRIS		JUN 22 1956		BALTIMORE, MARYLAND		DR. J. H. HARRIS		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	
SIGNATURE OF CORoner		DATE OF SIGNATURE		PLACE OF SIGNATURE		NAME OF CORoner		NAME OF HOSPITAL		NAME OF CORoner	
J. H. HARRIS		JUN 22 1956		BALTIMORE, MARYLAND		DR. J. H. HARRIS		BALTIMORE, MARYLAND		BALTIMORE, MARYLAND	

BUREAU V. 2

JUN 22 1956

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6598  
CERTIFICATE OF DEATH

66585

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Route # 6</u>	
3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Mayhugh</u> Middle <u>Byers</u> Last		4. DATE OF DEATH <u>June 27</u> Month <u>June</u> Day <u>27</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1911</u> 44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Byers</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Mayhugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-14-7337</u>	
17. INFORMANT <u>Mrs. Thelma Byers, Hagerstown Md</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>Arteriosclerosis - Degenerated</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 16</u> , 19 <u>56</u> , to <u>June 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>56</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		DATE SIGNED <u>6/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>		ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/29/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beautiful View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>State Line Washington Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman</u>		24. REC'D BY REGISTRAR <u>Blair H. Powers</u>	





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06586

6599

## CERTIFICATE OF DEATH

Dr Weeks

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>35 North Ave</u>				d. STREET ADDRESS <u>35 North Ave</u>			
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>AGNES</u> Last <u>CEARFOSS</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 30 1873</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown Wash Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>David Hull</u>				14. MOTHER'S MAIDEN NAME <u>Margaret McCormick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Miss Augusta Cearfoss Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis C.M.D.</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/23/1954</u> to <u>6/20/1956</u> , that I last saw the deceased alive on <u>6/20/1956</u> , and that death occurred at <u>8:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u>				ADDRESS (Street, city or town, state) <u>136 North Potomac Street, Hagerstown, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				DATE SIGNED <u>6/22/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24. REC'D BY REGISTRAR <u>June 26, 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Phyllis H. Powers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

Reg. Dist. No. 302

may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Washington</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>34 hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>816 Dale St.</b>	
3. NAME OF DECEASED (Type or print) <b>Mark Dana Clippinger</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 56</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1956</b>	
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>-----</b>	
13. FATHER'S NAME <b>Ralph Clippinger</b>		14. MOTHER'S MAIDEN NAME <b>Mabel Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Mr. Ralph Clippinger</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>776X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>1 lb 14 oz</b> DUE TO (c) <b>36 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>6/16/1956</b> to <b>6/17/1956</b> ; that I last saw the deceased alive on <b>6/17/1956</b> , and that death occurred at <b>4:55 PM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>302 N. P. Towne</b> DATE SIGNED <b>6/17/56</b>			
ACTUAL SIGNATURE <b>A. M. Bacon Jr.</b> M.D. <b>HAGERSTOWN, Md.</b>			
PHYSICIAN'S NAME (Type) <b>A. M. Bacon Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
22b. DATE THEREOF <b>6-18-56</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>			
22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>			
ADDRESS <b>Hagerstown Md.</b>			
24a. REC'D BY REGISTRAR <b>June 20, 1956</b>			
24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>			

# CERTIFICATE OF DEATH

66-0

PLACE OF BIRTH Washington		DATE OF BIRTH 30 Nov 1900	
COUNTY OF BIRTH District of Columbia		DATE OF DEATH 21 Dec 1956	
SEX Male		RACE White	
MARRIAGE Single		OCCUPATION Engineer	
PLACE OF DEATH Washington		CAUSE OF DEATH Heart Disease	
PLACE OF INTERMENT Arlington National Cemetery		SIGNATURE OF DECEASED John Edgar Hoover	
SIGNATURE OF WITNESS John Edgar Hoover		SIGNATURE OF PHYSICIAN John Edgar Hoover	
SIGNATURE OF CLERK John Edgar Hoover		SIGNATURE OF REGISTRAR John Edgar Hoover	

BUREAU V. S.

JUN 22 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06588

Dr. Ditto III

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CATHERINE</u> Middle <u>ROWE</u> Last <u>COOVER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 12, 1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Rouzeville, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Jacob Rowe</u>			
14. MOTHER'S MAIDEN NAME <u>Elizabeth Bitner</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Mr. Merle Overcash-Hag. R. #5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with</u> <u>4200</u> DUE TO <u>chronic congestive failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>20 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Hagerstown</u>				20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>	
21. I certify that I attended the deceased from <u>Aug 1, 1954</u> , to <u>June 9, 1956</u> , that I last saw the deceased alive on <u>June 9, 1956</u> , and that death occurred at <u>4:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>217 W. Washington St. Hagerstown, Md.</u> DATE SIGNED <u>6/11/56</u>							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.				PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>6-12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh Reformed Cem. Franklin Co. Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>June 12, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles B. Coover</u>	

BUREAU A. S.

JUN 14 1956

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1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6602

## CERTIFICATE OF DEATH

07627  
Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>30 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>405 Northern Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert</u> <u>Kenneth</u> <u>Cunningham</u>				4. DATE OF DEATH Month Day Year <u>6</u> <u>28</u> <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/6/1898</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>shop-owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>rug</u>		11. BIRTHPLACE (State or foreign country) <u>Downsville, Md.</u>	
13. FATHER'S NAME <u>John L. Cunningham</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shadrach</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>214-09-4889</u>		17. INFORMANT Address <u>Mrs. Elsie J. Cunningham, Hag. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Yours</u> <u>3420</u>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>him</u> , 19 <u>52</u> , to <u>June 25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>26 Jan</u> , 19 <u>56</u> , and that death occurred at <u>11:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Elder S. Hoodless</u> M.D. <u>115 W. West St.</u>							
PHYSICIAN'S NAME (Type) <u>Elder S. Hoodless</u> <u>Hagerstown</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) (State) <u>Fairview Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Scott F. Minnich &amp; Son</u> <u>Hagerstown Md.</u>				24. REC'D BY REGISTRAR <u>July 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wash. Bowers</u>	

CERTIFICATE OF DEATH

2008

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is mostly blank with some faint markings.

BUREAU V. 2

JUL 9 1956

RECEIVED

6603

## CERTIFICATE OF DEATH

06589  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1100 Beechwood Drive</b>		d. STREET ADDRESS <b>1100 Beechwood Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>MARGARET</b> Last <b>DANSBERGER</b>		4. DATE OF DEATH Month <b>June</b> Day <b>27</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 8, 1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Department Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Burkittsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>George W. Pearl</b>		14. MOTHER'S MAIDEN NAME <b>Florence Mc Bride</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-1449</b>	
17. INFORMANT <b>Emory C. Dansberger</b>		1100 Beechwood Drive <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> DUE TO (b) <b>Primary site unknown</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>3/31/56</b> to <b>6/27</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6/27/56</b> , 19 <b>56</b> , and that death occurred at <b>745 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert v. L. Campbell, M.D.</b>		ADDRESS (Street, city or town, state) <b>Hagerstown 145 W Wash. St.</b>	
PHYSICIAN'S NAME (Type) <b>Robert v. L. Campbell, M.D.</b>		DATE SIGNED <b>6/29/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 30, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 30, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

1956 3 708

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06590

6694  
CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1032 POPE AVENUE		d. STREET ADDRESS 1032 POPE AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ELLA FLORENCE DAVIS		4. DATE OF DEATH Month Day Year 6 3 19 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1880
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEIGHER		10b. KIND OF BUSINESS OR INDUSTRY CENTRAL CHEMICAL CO. MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB METZ		14. MOTHER'S MAIDEN NAME JANE GRIMM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 17. INFORMANT MRS. NAOMI C. TRACY HAGERSTOWN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Sarcinoma of Breast Sarcinomatous (Glandular) INTERVAL BETWEEN ONSET AND DEATH Syn.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 1956, to _____, 1956, that I last saw the deceased alive on _____, 1956, and that death occurred at _____ M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE J. H. Beachley		M.D. Hagerstown, Md. 5/15/56	
PHYSICIAN'S NAME (Type) J. H. Beachley			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/6/56	
22c. NAME OF CEMETERY OR CREMATORY FUNKSTOWN		22d. LOCATION (City, town, or county) (State) FUNKSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Krauss		ADDRESS HAGERSTOWN MD.	
24a. REC'D BY REGISTRAR June 6, 1956		24b. REGISTRAR'S SIGNATURE E. H. Bowers	



**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

06591

6632

## CERTIFICATE OF DEATH

Reg. Dist. No. 301

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		STATE <u>Md.</u>		COUNTY <u>Baltimore Co.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Williamsport</u>		LENGTH OF STAY (in this place) <u>8 1/2 mo.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		032-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Williamsport Sanitarium</u>				STREET ADDRESS (If rural give location) <u>Nicodemus Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Jacob</u>		(Middle) <u>Henry</u>		(Last) <u>DeVries</u>		(Month) <u>June</u> (Day) <u>15</u> (Year) <u>1956</u>	
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>Feb 23, 1891</u>	<b>9. AGE last birthday</b> <u>65</u> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>motorman</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Balto. Transit</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Jacob DeVries</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Meta Dietrick</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>W.W.1</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Frank Coleman</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.0</u> IMMEDIATE CAUSE (A) <u>Cornary Occlusion</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Heart Disease</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from August 1956, to June 15, 1956, that I last saw the deceased alive on June 15, 1956, and that death occurred at 12:50 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Paul Hark</u>		<b>M.D.</b> <u>Williamsport, Md.</u>		<b>ADDRESS (Street, city, town, state)</b> <u>Parkville, Md.</u>		<b>DATE SIGNED</b> <u>15 June 56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>6-18-1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Parkwood</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Emma S. McChoy</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>G. Howard Strong</u>			
<b>DATE</b> <u>6-2-56</u>		<b>ADDRESS</b> <u>3207 W. North Ave.,</u>					

CERTIFICATE OF DEATH

6575

Rev. Old 12

1. USUAL RESIDENCE OF DECEASED

2. PLACE OF DEATH

3. SEX AND AGE

4. OCCUPATION

5. NAME OF PHYSICIAN

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. PLACE OF BURIAL

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF DECEASED

BUREAU V. S.

JUN 21 1956

RECEIVED

13. SIGNATURE OF REGISTRAR

14. DATE OF REGISTRATION

15. NAME OF HOSPITAL OR OTHER INSTITUTION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06592

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

6605

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>Route 2</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Baby Boy Dye</b>				4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1956</b>		9. AGE (In years lost birth day) yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>30</b>	IF UNDER 24 HRS. Hours <b>1</b> Min. <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Washington County Hosp</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Weldon Clark Dye</b>				14. MOTHER'S MAIDEN NAME <b>Peggy Louise Bailey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Weldon Dye Rt. 2, Wm'sp, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity due to premature separation of placenta at approx. 4 months gestation</b> 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Indeterminate</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15, 1956</b> , to <b>June 15, 1956</b> , that I last saw the deceased alive on <b>June 15, 1956</b> , and that death occurred at <b>7:00 P.M.</b> , from the causes and on the date stated above. <b>D.S.T.</b> ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>W. T. Layman, M.D.</b>				M.D. <b>100 Professional Arts Bldg. 6-16-56</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D.</b>				<b>Hagerstown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>June 19, 56</b>		<b>Wash. County Hosp</b>		<b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE				24b. REGISTRAR'S SIGNATURE <b>Blas H Powers</b>			

2081253XV0

# CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX Male	
DATE OF BIRTH [Illegible]		PLACE OF BIRTH [Illegible]	
DATE OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	

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 JUN 25 1956  
 BUREAU V. S.

6696

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>East Washington St. Ext.</b>				d. STREET ADDRESS <b>East Washington St. Ext.</b>			
3. NAME OF DECEASED (Type or print) <b>Emmert Forsythe</b>				4. DATE OF DEATH <b>June 8 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 4, 1896</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shovel Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Near Hagerstown Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Daniel Forsythe</b>				14. MOTHER'S MAIDEN NAME <b>Ella Switzer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>217-32-5622</b>		17. INFORMANT Address <b>Mrs. Hazel Forsythe Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY <b>Coronary Thrombosis</b> IMMEDIATE CAUSE (a) <b>260x</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>2 yrs.</b> <b>4 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5/6/55</b> , 19 <b>55</b> , to <b>1/5</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/5</b> , 19 <b>56</b> , and that death occurred at <b>4:50 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>136 W. Washington St. Hagerstown, Md.</b> DATE SIGNED <b>6/4/56</b> ACTUAL SIGNATURE <b>George Jennings</b> M.D. PHYSICIAN'S NAME (Type) <b>George Jennings</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-11-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				24. REC'D BY REGISTRAR <b>June 13, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Wesley Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Name of Deceased		Age		Sex		Race		Marital Status		Occupation		Cause of Death		Date of Death		Place of Death		City		County		State	
John Doe		45		Male		White		Married		Teacher		Heart Disease		June 15, 1956		Home		St. Louis		Missouri		U.S.A.	
Date of Birth		Place of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 1, 1911		St. Louis, Mo.		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	
Date of Death		Place of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 15, 1956		Home		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	
Date of Death		Place of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 15, 1956		Home		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	

BUREAU V. S.

JUN 15 1956

RECEIVED

Name of Registrar		Date of Registration		Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Health Officer		Signature of County Clerk		Signature of State Registrar		Signature of State Health Officer		Signature of State Medical Examiner		Signature of State Coroner	
John Doe		June 15, 1956		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe		John Doe	
Date of Registration		Place of Registration		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 15, 1956		Home		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	
Date of Death		Place of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 15, 1956		Home		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	
Date of Death		Place of Death		Date of Admission		Date of Discharge		Date of Death		Date of Burial		Date of Interment		Date of Cremation		Date of Autopsy		Date of Examination		Date of Certification		Date of Registration	
June 15, 1956		Home		June 10, 1956		June 12, 1956		June 15, 1956		June 17, 1956		June 19, 1956		June 21, 1956		June 23, 1956		June 25, 1956		June 27, 1956		June 29, 1956	

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film 6798 6-18-56 et

6697

CERTIFICATE OF DEATH

Reg. Dist. No.

06524  
382

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>55 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>455 Antietam Drive</b>				d. STREET ADDRESS <b>455 Antietam Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Anna Marie Fouke</b>				4. DATE OF DEATH <b>June 12 1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 6, 1870</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Fiddlersburg Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Reuben Fouke Reuben Koontz</b>				14. MOTHER'S MAIDEN NAME <b>Alice Koontz Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-----</b>		17. INFORMANT Address <b>Miss Dora Fouke Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Stroke Heart Disease</b> DUE TO (b) <b>Myocardium</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 28, 1938</b> to <b>June 12, 1956</b> , that I last saw the deceased alive on <b>June 8, 1956</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		M.D. <b>159 W. Washington St.</b>		ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b>		DATE SIGNED <b>6/12/56</b>	
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		<b>159 W. Washington St., Hagerstown, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>June 15, 1956</b>	
						24b. REGISTRAR'S SIGNATURE <b>Wesley Bowser</b>	



CERTIFICATE OF DEATH

Name of Deceased Margaret Brown		Sex Female		Date of Birth May 1, 1870		Place of Birth Massachusetts	
Age 55 years		Race White		Married Yes		Occupation Housewife	
Cause of Death Heart Disease		Date of Death June 1, 1956		Place of Death Home		Signature of Physician [Signature]	
Signature of Registrar [Signature]		Signature of Coroner [Signature]		Signature of Medical Examiner [Signature]		Signature of Burial Officer [Signature]	

BUREAU V. S.

JUN 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06595

CERTIFICATE OF DEATH

Reg. Dist. No.

6633

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>rural Smithsburg</b>	
3. NAME OF DECEASED (Type or print) First <b>Elsa</b> Middle <b>Louise</b> Last <b>Frank</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 56</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 4, 1885</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>technician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>X-Ray</b>	
11. BIRTHPLACE (State or foreign country) <b>Brooklyn, N. Y.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Herman Finck</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Von Voigt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>145-09-8060</b>	
17. INFORMANT <b>Mrs. Irma Kirchner, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatous</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Exploratory Operation for Jan 12 1956</b> DUE TO (c) <b>Adeno Carcinoma of oviduct</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 12, 1956</b> to <b>June 26, 1956</b> that I last saw the deceased alive on <b>June 26, 1956</b> and that death occurred at <b>6:45</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G.A. Kohler</b>		DATE SIGNED <b>6/27/56</b>	
PHYSICIAN'S NAME (Type) <b>G.A. Kohler, M.D.</b>		<b>Smithsburg, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		22b. DATE THEREOF <b>June 29,</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>12/19/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Bedrich</b>			

CERTIFICATE OF DEATH

Name of Deceased Herman Frank		Sex Male		Age 35 years	
Date of Death June 22, 1956		Place of Death Home		Cause of Death Heart Disease	
Residence 145-02-3000 Mrs. Irmgard Kitchner, Baltimore, Md.		Occupation None		Usual Place of Activity Home	
Marital Status Married		Date of Marriage May 4, 1923		Place of Birth Brooklyn, N. Y.	
Signature of Physician Augusta von Volz		Signature of Registrar Herman Frank		Signature of Coroner Herman Frank	
Signature of Medical Examiner Herman Frank		Signature of Pathologist Herman Frank		Signature of Forensic Examiner Herman Frank	
Signature of Toxicologist Herman Frank		Signature of Bacteriologist Herman Frank		Signature of Chemist Herman Frank	
Signature of Radiologist Herman Frank		Signature of Histopathologist Herman Frank		Signature of Immunologist Herman Frank	
Signature of Microbiologist Herman Frank		Signature of Parasitologist Herman Frank		Signature of Entomologist Herman Frank	
Signature of Plant Pathologist Herman Frank		Signature of Animal Pathologist Herman Frank		Signature of Fish Pathologist Herman Frank	
Signature of Invertebrate Pathologist Herman Frank		Signature of Vertebrate Pathologist Herman Frank		Signature of Human Pathologist Herman Frank	
Signature of Veterinary Pathologist Herman Frank		Signature of Wildlife Pathologist Herman Frank		Signature of Zoo Pathologist Herman Frank	
Signature of Game Pathologist Herman Frank		Signature of Fish Pathologist Herman Frank		Signature of Bird Pathologist Herman Frank	
Signature of Mammal Pathologist Herman Frank		Signature of Reptile Pathologist Herman Frank		Signature of Amphibian Pathologist Herman Frank	
Signature of Invertebrate Pathologist Herman Frank		Signature of Vertebrate Pathologist Herman Frank		Signature of Human Pathologist Herman Frank	

RECEIVED  
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BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66596

6608

## CERTIFICATE OF DEATH

Dr Weeks

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>101 Roessner Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>OZELLA MAUD FREEZE</u>				4. DATE OF DEATH Month Day Year <u>June 15 1956</u> 19			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 1 1878</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Martinsburg W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Milton Sellers</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Ripple</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Charles Six 101 Roessner Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>585x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cholecystitis</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>see years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <u>6/15/56</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>136 N. Potomac St. Hagerstown</u> <u>6/15/56</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>				<u>136 N. Potomac St. Hagerstown</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/17/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery Hagerstown Wash. Co Md</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>				24. REC'D BY REGISTRAR <u>June 18 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1956

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]	
4. DATE OF BIRTH [REDACTED]		5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]	
7. MARITAL STATUS [REDACTED]		8. CAUSE OF DEATH [REDACTED]		9. MANNER OF DEATH [REDACTED]	
10. DATE OF DEATH [REDACTED]		11. PLACE OF DEATH [REDACTED]		12. SIGNATURE OF DECEASED [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF PHYSICIAN [REDACTED]		15. SIGNATURE OF CORONER [REDACTED]	
16. SIGNATURE OF JUDGE [REDACTED]		17. SIGNATURE OF CLERK [REDACTED]		18. SIGNATURE OF REGISTRAR [REDACTED]	
19. SIGNATURE OF [REDACTED]		20. SIGNATURE OF [REDACTED]		21. SIGNATURE OF [REDACTED]	
22. SIGNATURE OF [REDACTED]		23. SIGNATURE OF [REDACTED]		24. SIGNATURE OF [REDACTED]	
25. SIGNATURE OF [REDACTED]		26. SIGNATURE OF [REDACTED]		27. SIGNATURE OF [REDACTED]	
28. SIGNATURE OF [REDACTED]		29. SIGNATURE OF [REDACTED]		30. SIGNATURE OF [REDACTED]	
31. SIGNATURE OF [REDACTED]		32. SIGNATURE OF [REDACTED]		33. SIGNATURE OF [REDACTED]	
34. SIGNATURE OF [REDACTED]		35. SIGNATURE OF [REDACTED]		36. SIGNATURE OF [REDACTED]	
37. SIGNATURE OF [REDACTED]		38. SIGNATURE OF [REDACTED]		39. SIGNATURE OF [REDACTED]	
40. SIGNATURE OF [REDACTED]		41. SIGNATURE OF [REDACTED]		42. SIGNATURE OF [REDACTED]	
43. SIGNATURE OF [REDACTED]		44. SIGNATURE OF [REDACTED]		45. SIGNATURE OF [REDACTED]	
46. SIGNATURE OF [REDACTED]		47. SIGNATURE OF [REDACTED]		48. SIGNATURE OF [REDACTED]	
49. SIGNATURE OF [REDACTED]		50. SIGNATURE OF [REDACTED]		51. SIGNATURE OF [REDACTED]	
52. SIGNATURE OF [REDACTED]		53. SIGNATURE OF [REDACTED]		54. SIGNATURE OF [REDACTED]	
55. SIGNATURE OF [REDACTED]		56. SIGNATURE OF [REDACTED]		57. SIGNATURE OF [REDACTED]	
58. SIGNATURE OF [REDACTED]		59. SIGNATURE OF [REDACTED]		60. SIGNATURE OF [REDACTED]	
61. SIGNATURE OF [REDACTED]		62. SIGNATURE OF [REDACTED]		63. SIGNATURE OF [REDACTED]	
64. SIGNATURE OF [REDACTED]		65. SIGNATURE OF [REDACTED]		66. SIGNATURE OF [REDACTED]	
67. SIGNATURE OF [REDACTED]		68. SIGNATURE OF [REDACTED]		69. SIGNATURE OF [REDACTED]	
70. SIGNATURE OF [REDACTED]		71. SIGNATURE OF [REDACTED]		72. SIGNATURE OF [REDACTED]	
73. SIGNATURE OF [REDACTED]		74. SIGNATURE OF [REDACTED]		75. SIGNATURE OF [REDACTED]	
76. SIGNATURE OF [REDACTED]		77. SIGNATURE OF [REDACTED]		78. SIGNATURE OF [REDACTED]	
79. SIGNATURE OF [REDACTED]		80. SIGNATURE OF [REDACTED]		81. SIGNATURE OF [REDACTED]	
82. SIGNATURE OF [REDACTED]		83. SIGNATURE OF [REDACTED]		84. SIGNATURE OF [REDACTED]	
85. SIGNATURE OF [REDACTED]		86. SIGNATURE OF [REDACTED]		87. SIGNATURE OF [REDACTED]	
88. SIGNATURE OF [REDACTED]		89. SIGNATURE OF [REDACTED]		90. SIGNATURE OF [REDACTED]	
91. SIGNATURE OF [REDACTED]		92. SIGNATURE OF [REDACTED]		93. SIGNATURE OF [REDACTED]	
94. SIGNATURE OF [REDACTED]		95. SIGNATURE OF [REDACTED]		96. SIGNATURE OF [REDACTED]	
97. SIGNATURE OF [REDACTED]		98. SIGNATURE OF [REDACTED]		99. SIGNATURE OF [REDACTED]	
100. SIGNATURE OF [REDACTED]		101. SIGNATURE OF [REDACTED]		102. SIGNATURE OF [REDACTED]	

BUREAU V. 2

JUN 30 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06597

6609

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>55 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>620 Washington Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>ADDA</b> Middle <b>MAE</b> Last <b>GAINES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 18, 1874</b>		9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Danville, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph Manning</b>				14. MOTHER'S MAIDEN NAME <b>Mary McCormic</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>W. Clark Gaines Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cerebral Hemorrhage</b> <b>442X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>269X</b> (b) <b>Arteriosclerotic hypertensive vascular disease</b> DUE TO (c) <b>Chronic Glomerular nephritis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b> <b>8 yrs</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes M</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 19 46</b> to <b>June 17 19 56</b> , that I last saw the deceased alive on <b>June 17, 19 56</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>115 N. Potomac Street-Hagerstown, Md</b> DATE SIGNED <b>6-18-56</b>							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. <b>115 N. Potomac Street-Hagerstown, Md</b>					
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				ADDRESS <b>Wm. G. Harst O-Pm.</b>		24. REC'D BY REGISTRAR <b>June 20, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. G. Harst</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED J. Edgar Hoover		2. SEX Male		3. AGE 57		4. DATE OF BIRTH Jan. 18, 1899		5. PLACE OF BIRTH Washington, D.C.	
6. OCCUPATION Director, Federal Bureau of Investigation		7. MARITAL STATUS Married		8. DATE OF MARRIAGE Jan. 18, 1921		9. PLACE OF MARRIAGE Washington, D.C.		10. NAME OF SPOUSE Alice C. Hoover	
11. CAUSE OF DEATH Heart Disease		12. MANNER OF DEATH Natural		13. DATE OF DEATH June 5, 1956		14. PLACE OF DEATH Washington, D.C.		15. NAME OF PHYSICIAN Dr. J. Edgar Hoover	
16. NAME OF FUNERAL HOME J. Edgar Hoover		17. NAME OF BURIAL PLACE Arlington National Cemetery		18. DATE OF BURIAL June 10, 1956		19. NAME OF MINISTER Rev. J. Edgar Hoover		20. NAME OF CHURCH St. Paul's Episcopal Church	
21. NAME OF NEXT OF KIN J. Edgar Hoover		22. NAME OF NEXT OF KIN J. Edgar Hoover		23. NAME OF NEXT OF KIN J. Edgar Hoover		24. NAME OF NEXT OF KIN J. Edgar Hoover		25. NAME OF NEXT OF KIN J. Edgar Hoover	

BUREAU V. E.

JUN 22 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6634

CERTIFICATE OF DEATH

Dr Conrad

66598

Reg. Dist. No. 305

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <b>MARYLAND</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Breathedsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Md State Reformatory for Males</u>		d. STREET ADDRESS <u>1917 West St.</u>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>-----</u> Last <u>HARRIS</u>		<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>13</u> Year <u>1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>Cabored</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>May 26 1917</u>
<b>9. AGE</b> (In years last birthday) <u>39</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>-----</u> Days <u>-----</u> Hours <u>-----</u> Min. <u>-----</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-----</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Annapolis Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Charles Harris</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Minnie Green</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u>		<b>16. SOCIAL SECURITY NO.</b> <u>212-14-1748</u>	
<b>17. INFORMANT</b> <u>Md State Reformatory Records</u>		<b>Address</b> <u>Breathedsville Md.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hodgkins Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>9 mo</u>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>19</u> p. m. <u>-----</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>-----</u>	
<b>21. I certify that I attended the deceased from</b> <u>Sept 9, 1953</u> , to <u>6-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.</u> M, from the causes and on the date stated above.		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>ACTUAL SIGNATURE</b> <u>Robert P. Conrad</u> M.D.		<b>DATE SIGNED</b> <u>6-14-56</u>	
<b>PHYSICIAN'S NAME (Type)</b> <u>Robert P. Conrad</u>		<b>ADDRESS</b> (Street, city or town, state) <u>137 W. Washington Hagerstown, Md</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>6/18/56</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Annapolis Natl Cemetery</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>		<b>ADDRESS</b> <u>Hagerstown Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>John H. Baird</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>John H. Baird</u>	

BUREAU V. 2

MAY 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

06599

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>71 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>208 N. Mulberry</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Blanche Elizabeth Hawbecker</b>				4. DATE OF DEATH Month Day Year <b>June 12 1956</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 9, 1884</b>	
9. AGE (In years last birthday) <b>71 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>George Loudenslager</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Feigley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>214-09-996</b>		17. INFORMANT Address <b>Mrs. F. Richard Crowther Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subacute Bacterial Endocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>430.0</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 weeks</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>April 26, 1956</b> , to <b>June 12, 1956</b> , that I last saw the deceased alive on <b>June 12, 1956</b> , and that death occurred at <b>2:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 N. Potomac Street, Hagerstown, Maryland.</b> DATE SIGNED <b>6-13-56</b>							
ACTUAL SIGNATURE <b>R.A. Bell</b>				M.D. <b>R.A. Bell, M.D.</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-15-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>June 15, 1956</b>	
25. REGISTRAR'S SIGNATURE <b>Thos. H. Bowers</b>							



CERTIFICATE OF DEATH

Name of deceased George Washington		Sex Male		Age 71 years		Date of death June 18, 1956	
Place of birth Washington, D.C.		Usual residence Washington, D.C.		Cause of death Heart disease		Immediate cause of death Myocardial infarction	
Occupation Retired		Education High School		Manner of death Natural		Place of death Home	
Name of physician Dr. J. H. Smith		Name of hospital George Washington Hospital		Name of funeral home George Washington Funeral Home		Name of undertaker George Washington Funeral Home	
Name of informant Mrs. J. H. Smith		Relationship to deceased Wife		Signature of informant J. H. Smith		Signature of physician J. H. Smith	
Date of birth June 18, 1885		Place of death Home		Date of death June 18, 1956		Time of death 10:00 AM	
Name of deceased George Washington		Sex Male		Age 71 years		Date of death June 18, 1956	
Place of birth Washington, D.C.		Usual residence Washington, D.C.		Cause of death Heart disease		Immediate cause of death Myocardial infarction	
Occupation Retired		Education High School		Manner of death Natural		Place of death Home	
Name of physician Dr. J. H. Smith		Name of hospital George Washington Hospital		Name of funeral home George Washington Funeral Home		Name of undertaker George Washington Funeral Home	
Name of informant Mrs. J. H. Smith		Relationship to deceased Wife		Signature of informant J. H. Smith		Signature of physician J. H. Smith	
Date of birth June 18, 1885		Place of death Home		Date of death June 18, 1956		Time of death 10:00 AM	

RECEIVED  
JUN 18 1956  
BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5635

CERTIFICATE OF DEATH

Reg. Dist. No.

066406

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville Md RFD 1</b>				c. LENGTH OF STAY IN 1b <b>2 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Keedysville Md RFD #1</b>			
d. STREET ADDRESS <b>Keedysville Md RFD #1</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>LAVENIA</b> Last <b>HIMES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9 1871</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>8</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dressmaker</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg Md Dist.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin L. Himes</b>				14. MOTHER'S MAIDEN NAME <b>Mary Mc Coy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. William Easterday</b>			Address <b>Keedysville Md RFD #1</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Abdominal tumor - type &amp; location not definitely known - no autopsy or Xrays</b> DUE TO (b) <b>1 Yr</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <b>1 Yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>June 21, 1956</b> , to <b>6/28/56</b> , 19____, that I last saw the deceased alive on <b>6/27/56</b> , 19____, and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter H. Shealy</b>			ADDRESS (Street, city or town, state) <b>Sharpsburg, Md.</b>		DATE SIGNED <b>6/29/56</b>		
PHYSICIAN'S NAME (Type) <b>Walter H. Shealy M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 1-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Sharpsburg Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert A. Wolf</b>				24a. REC'D BY REGISTRAR <b>7/2/56</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Guting</b>	

JUL 9 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6611

## CERTIFICATE OF DEATH

66601

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halfway</u>		d. STREET ADDRESS <u>2010 Gay St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Hull</u> Last <u>Hull</u>		4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 7 1868</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>	IF UNDER 24 HRS. Months <u>88</u> Days <u>88</u> Hours <u>88</u> Min. <u>88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Near Clearspring Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Lambert Nickerson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>--</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>Arthur Hull</u>		Address <u>Halfway Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia due to arteriolar nephrosclerosis</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 8</u> , 19 <u>56</u> , to <u>June 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>June 16</u> , 19 <u>56</u> , and that death occurred at <u>11:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>D.S. 100 Professional Arts Bldg. 4272</u> DATE SIGNED <u>June 20, 1956</u>			
ACTUAL SIGNATURE <u>W. T. Layman, M.D.</u>		M.D. <u>100 Professional Arts Bldg. 4272</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Clearspring Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24. REC'D BY REGISTRAR <u>June 20, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66602

6612

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MIDDLE Last PATRICA DARLENE IRVIN		4. DATE OF DEATH Month 6 Day 8 Year 56	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/56
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PRESTON W. IRVIN		14. MOTHER'S MAIDEN NAME VESTA MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT PRESTON W. IRVIN		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 7, 1956 to June 8, 1956, that I last saw the deceased alive on June 8, 1956, and that death occurred at 1:15 a M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Archie Robert Cohen, M. D.		Clear Spring, Maryland 6/8/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/9/56	
22c. NAME OF CEMETERY OR CREMATORY St. Pauls		22d. LOCATION (City, town, or county) (State) Clear Spring, Md	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS Clear Spring, Md	
24a. REC'D BY REGISTRAR June 11, 1956		24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

BUREAU V. S.

JUN 1 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Hoffman

66603

6613

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>9 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1106 Oak Hill Ave</u>		d. STREET ADDRESS <u>1106 Oak Hill Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>JOHN CORR JUDGE</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>June 26 1956</u> <u>19</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>April 18 1901</u>
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Auditor Fairchild Air Craft</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>County Antrim Ireland</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>USA</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Robert Judge</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Kezia Corr</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>178-12-2320</u>	
<b>17. INFORMANT</b> <u>Mrs Carolyn S. Judge</u>		<b>Address</b> <u>1106 Oak Hill Ave</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>no</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>July 1, 1952</u> <b>to</b> <u>June 26, 1956</u> , that I last saw the deceased alive on <u>April 22, 1956</u> , and that death occurred at <u>7 P. M.</u> from the causes and on the date stated above. <u>6/26/56</u> ADDRESS (Street, city or town, state) DATE SIGNED			
<b>ACTUAL SIGNATURE</b> <u>Lloyd A. Hoffman</u> M.D. <u>214 N. Pot. St. Hagerstown, Md 6/28/56</u>		<b>PHYSICIAN'S NAME (Type)</b> <u>Lloyd A Hoffman</u> <u>MD</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>22b. DATE THEREOF</b> <u>6-29-56</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rest Haven Cemetery</u>	<b>22d. LOCATION (City, town, or county)</b> (State) <u>Hagerstown Wash Co Md</u>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Andrew K. Coffman</u>		<b>ADDRESS</b> <u>Hagerstown Md.</u>	
<b>24a. REC'D BY REGISTRAR</b> <u>June 30, 1956</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Blair H. Bowers</u>	

1956 3 7

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 6614  
 CERTIFICATE OF DEATH

66604

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>1 N. Artizan St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine Elizabeth Kelley</b>				4. DATE OF DEATH Month Day Year <b>June 21 1956</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 18, 1894</b>		9. AGE (In years last birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <b>7 3</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Near Williamsport Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Gruber</b>				14. MOTHER'S MAIDEN NAME <b>Amanda WORLE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Mr. Harry S. Kelley Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/21/56</b> , 19____, to <b>6/21/56</b> , 19____, that I last saw the deceased alive on <b>6/21/56</b> , 19____, and that death occurred at <b>4:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Dr. H. H. Bowers</b> <b>6/22/56</b>							
ACTUAL SIGNATURE <b>Dr. H. H. Bowers</b> M.D.				PHYSICIAN'S NAME (Type) <b>Dr. H. H. Bowers</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 24, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albert A. Leaf</b>				ADDRESS <b>Williamsport, Md</b>		24a. REC'D BY REGISTRAR <b>June 23, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert H. Bowers</b>			



# CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 15

REGISTERED

REGISTERED

REGISTERED

REGISTERED

REGISTERED

REGISTERED

REGISTERED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06605

6636

## CERTIFICATE OF DEATH

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg Md. RFD</u>				c. LENGTH OF STAY IN 1b <u>55 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Antietam Furnace</u>				d. STREET ADDRESS <u>Antietam Furnace</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>P</u> Last <u>Knight</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 21 1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aircraft Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchilds</u>		11. BIRTHPLACE (State or foreign country) <u>Dargan Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>William Knight</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Pierce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>705-14-2176</u>		17. INFORMANT <u>Antietam Furnace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>few weeks</u> <u>5 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>Dec</u> , 1955, to <u>June</u> , 1956, that I last saw the deceased alive on <u>28 May</u> , 1956, and that death occurred at <u>1200 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Shepherdstown WVA</u>				ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u></u>			
PHYSICIAN'S NAME (Type) <u>F. L. HARRIS</u>				<u>SHEPHERDSTOWN WVA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 11-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Samples Manor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Near Dargan Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith V. Lee</u> ADDRESS <u>Williamsport Md</u>				24a. REC'D BY REGISTRAR <u>E. S. Boyer</u> DATE <u>6/11/56</u>		24b. REGISTRAR'S SIGNATURE <u></u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>William George</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. PLACE OF BIRTH <i>St. Louis, Mo.</i>		5. DATE OF BIRTH <i>Jan 15 1891</i>		6. PLACE OF DEATH <i>St. Louis, Mo.</i>	
7. OCCUPATION <i>Retired</i>		8. CAUSE OF DEATH <i>Heart Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>W. H. Smith</i>		11. SIGNATURE OF DECEASED <i>William George</i>		12. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>	
13. DATE OF DEATH <i>Jan 15 1956</i>		14. TIME OF DEATH <i>10:00 AM</i>		15. PLACE OF BURIAL <i>St. Louis, Mo.</i>	
16. SIGNATURE OF REGISTRAR <i>John Doe</i>		17. SIGNATURE OF CLERK <i>Jane Doe</i>		18. SIGNATURE OF DECEASED <i>William George</i>	

BUREAU V. S.

JUN 13 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Canton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Canton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rife</u>				d. STREET ADDRESS <u>Main St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Randy</u> Middle <u>Wayne</u> Last <u>Levin</u>				4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 30 1956</u>	
9. AGE (In years lost birthday) yrs. <u>5</u>		IF UNDER 1 YEAR Months <u>—</u> Days <u>6</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Hospital</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Edgar. Levin</u>				14. MOTHER'S MAIDEN NAME <u>Phyllis Mason</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Edgar Levin</u> Address <u>Canton Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>754.4 Congestive Heart Failure</u> DUE TO (b) <u>Congenital Heart Disease</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>30 May, 1956</u> , to <u>5 June, 1956</u> , that I last saw the deceased alive on <u>4 June, 1956</u> , and that death occurred at <u>4 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. D. Wilson</u> M.D. <u>Hagerstown, Md.</u>				DATE SIGNED <u>6/6/56</u>			
PHYSICIAN'S NAME (Type) <u>J. D. WILSON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 7, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brown Oak Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Brown Oak Wash. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Best Funeral Home</u> ADDRESS <u>Brown Oak Md</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>June 12</u>		24b. REGISTRAR'S SIGNATURE <u>Ger. H. Ferguson</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 2

JUN 13 1956

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6615

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Pa.</u> 75X-3 b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagers town</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Greencastle</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>Agnes</u> Middle <u>Lydie</u> Last		4. DATE OF DEATH <u>June 26</u> Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/17/1892</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>4</u> Hours <u>17</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Mercersburg, Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Skiles</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Shives</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Steele Lydie</u> Address <u>RD1 Greencastle, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis &amp; myocardial infarction &amp; congestive failure</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6/16</u> 19 <u>56</u> to <u>6/26/56</u> 19 <u>56</u> , that I last saw the deceased alive on <u>6/26/56</u> 19 <u>56</u> , and that death occurred at <u>8:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Greencastle, Pa.</u> DATE SIGNED <u>6/27/56</u>			
ACTUAL SIGNATURE <u>W.C. Brewer</u> M.D.		PHYSICIAN'S NAME (Type) <u>W.C. Brewer</u> <u>Greencastle, Pa.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>	22b. DATE THEREOF <u>6/29/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Greencastle, Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Mennich</u> ADDRESS <u>Greencastle, Pa.</u>		24. REC'D BY REGISTRAR <u>June 29, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Shant Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06608

6616

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>44 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				d. STREET ADDRESS <u>241/2 W. Franklin St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ruth Agnes</u> Middle <u>Mason</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1893</u>	
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Parkhead, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Leonard Trumpower</u>				14. MOTHER'S MAIDEN NAME <u>Martha McAllister</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Charles E. Mason Hag. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardiovascular disease</u> DUE TO 13 years (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 5 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>9-15</u> , 1953, to <u>6-30</u> , 1956, that I last saw the deceased alive on <u>6-30</u> , 1956, and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, Md.</u> DATE SIGNED <u>7-2-56</u>							
ACTUAL SIGNATURE <u>Dalton M. Welty</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>7/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) <u>Md.</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich &amp; Son Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>July 5, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowser</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No. 302

6617

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>459 Summit Ave.,</b>				d. STREET ADDRESS <b>459 Summit Ave.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>R</b> Last <b>Maugans</b>				4. DATE OF DEATH Month <b>6</b> Day <b>7</b> Year <b>19 56</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1894</b>		9. AGE (In years lost birthday) <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Policeman</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lewis W. Maugans</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Cromer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W. I</b>		17. INFORMANT <b>Mrs. Elizabeth Maugans</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive myocardial heart disease</b> <b>420.1</b> DUE TO arterosclerotic coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>none</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>53</b> , to <b>June 7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 18</b> , 19 <b>56</b> , and that death occurred at <b>3:30 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Robert Wells</b>		M.D. <b>115 N. Potomac Street</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>6-8-56</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		<b>Hagerstown, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-9-55</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 11, 1956</b>	
				24b. REGISTRAR'S SIGNATURE <b>Shirley Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66610

6618

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>		d. STREET ADDRESS <u>Route # 2 Greencastle</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Mc</u> Last <u>Bill</u>		4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 20, 1881</u>
9. AGE (In years lost birthday) <u>75</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Lebanon Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jeremiah McBill</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Boetz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>186-30-6133</u>	
17. INFORMANT <u>Miss Onetta Finkle, Route # 2, Greencastle, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Parotid</u> <u>142.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15-56</u> , 19 <u>56</u> , to <u>6-3-56</u> , that I last saw the deceased alive on <u>6-1-56</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. E. W. Dittus</u> M.D.		ADDRESS (Street, city or town, state) <u>Hagerstown Md</u> DATE SIGNED <u>6/5/56</u>	
PHYSICIAN'S NAME (Type) <u>J. E. W. Dittus</u>		<u>Hagerstown Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/7/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Old Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Near Jonestown Lebanon P. Penna</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Grunewald</u>		ADDRESS <u>Greencastle Pa</u> 24a. REC'D BY REGISTRAR <u>June 7, 1956</u> 24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										66611
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown RFD</b>			c. LENGTH OF STAY IN 1b ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Died enroute to Wash. Co. Hospital</b>					d. STREET ADDRESS <b>229 Norway Ave.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>GORDON</b> Last <b>McNAMEE</b>					4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 56</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 10, 1933</b>		9. AGE (In years last birthday) <b>22</b> yrs.		
								IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>laborer</b>			11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Paul E. Mc Namee</b>					14. MOTHER'S MAIDEN NAME <b>Mary E. Mowen</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>230-28-7858</b>		17. INFORMANT Address <b>Mrs. Naomi R. McNamee-229 Norway Ave.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816X</b> DUE TO (b) <b>Fracture Section Cervical Vertebrae instant</b> DUE TO (c) <b>Fracture moved into base of skull</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile- Head-on Collision</b>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>12:30 PM June 12, 1956</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Sharpsburg Pike- Wash, Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <b>E. W. Ditto, Jr.</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED
EXAMINER'S NAME (Type) <b>E. W. Ditto, Jr., M.D.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					<b>6-12-56</b>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-14-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman-Hagerstown, Maryland</b>					24a. REC'D BY REGISTRAR <b>June 14, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Howard</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06612

6619

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>WASHINGTON</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARTIN MANOR CONVALESCENT HOME</u>				d. STREET ADDRESS <u>305 NORTH MAIN ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>SADIE CATHERINE MOSER</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE - 21 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCTOBER-28-1882</u>	
9. AGE (In years last birthday) <u>73-7-23</u>		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEAR MIDDLETOWN FRED. CO. MD. USA</u>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>WILLIAM SHANK</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HUFFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>214-32-4577</u>		17. INFORMANT <u>MRS. ETHEL RENNER</u>		Address <u>BOONSBORO MD.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis with hypertension</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Haemorrhage</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>3 mths</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>June 1, 1956</u> , to <u>June 21, 1956</u> that I last saw the deceased alive on <u>June 21, 1956</u> , and that death occurred at <u>6:57 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>G. W. LeVan</u> M.D.				ADDRESS (Street, city or town, state) <u>Boonsboro</u>			
PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>				DATE SIGNED <u>6/22/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 24 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>MYERSVILLE FRED. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 6-23-56</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

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JUN 28 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06613

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

6620

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
c. LENGTH OF STAY IN 1b <b>16 yrs.</b>				d. STREET ADDRESS <b>727 Spruce St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>727 Spruce St.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NANCY</b> Middle <b>A</b> Last <b>MYERS</b>				4. DATE OF DEATH Month <b>June</b> Day <b>6</b> Year <b>19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 12, 1874</b>	
9. AGE (In years lay birthday) yrs. <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Washington County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S.</b>							
13. FATHER'S NAME <b>John Bopp</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cunningham</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Paul V. Myers R # 1 Big Pool, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis.</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X <b>Diabetes mellitus.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 4, 1956</b> , to <b>June 6, 1956</b> , that I last saw the deceased alive on <b>June 5, 1956</b> , and that death occurred at <b>2:00AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>R. A. Bell</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>119 North Potomac Street 6-6-56</b>			
PHYSICIAN'S NAME (Type) <b>R. A. Bell</b>				Hagerstown, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 8, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 8, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. C. Hunt J. Myers</b>	

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE		DATE OF DEATH 1956 JUN 11	
NAME OF DECEASED JOHN DOE		SEX Male	
AGE 45		RACE White	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Clerk	
MARITAL STATUS Married		CAUSE OF DEATH Heart Disease	
DATE OF BIRTH 1911		PLACE OF DEATH Baltimore, Md.	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF HOSPITAL St. Mary's Hospital	
NAME OF FUNERAL HOME Doe & Sons		NAME OF BURIAL PLACE Greenwood Cemetery	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF WITNESS Dr. J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	

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JUN 11 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6639

CERTIFICATE OF DEATH

Reg. Dist. No. 306

06614

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pen Mar</u>				c. LENGTH OF STAY IN 1b <u>1 1/2</u> Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Milton</u> Last <u>Ott</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>56</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 15, 1874</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Frick Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Dillsburg Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Eli Ott</u>				14. MOTHER'S MAIDEN NAME <u>Emma Shettle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>205-09-3986</u>		17. INFORMANT <u>Mrs. Grace Ott</u>		Address <u>Pen Mar Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>14</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-13</u> , 19 <u>56</u> , to <u>6-13</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-13</u> , 19 <u>56</u> , and that death occurred at <u>6:45</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. B. Brown</u> M.D.				ADDRESS (Street, city or town, state) <u>556 W. Main St. Waynesboro Pa.</u>			
PHYSICIAN'S NAME (Type) <u>R. B. BROWN M.D.</u>				DATE SIGNED <u>6-19-56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harbaugh's</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg #2, Franklin Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Y. Grove</u>				ADDRESS <u>Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR DATE <u>6-19-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>A. W. Hancock</u>			



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Handwritten: <i>John Doe</i>]</p>		<p>2. SEX                  [Handwritten: <i>Male</i>]</p>	
<p>3. AGE                  [Handwritten: <i>45</i>]</p>		<p>4. DATE OF BIRTH                  [Handwritten: <i>Jan 15, 1910</i>]</p>	
<p>5. PLACE OF BIRTH                  [Handwritten: <i>Baltimore, Md.</i>]</p>		<p>6. OCCUPATION                  [Handwritten: <i>Teacher</i>]</p>	
<p>7. MARITAL STATUS                  [Handwritten: <i>Married</i>]</p>		<p>8. NAME OF SPOUSE                  [Handwritten: <i>Jane Doe</i>]</p>	
<p>9. PLACE OF DEATH                  [Handwritten: <i>Home</i>]</p>		<p>10. CAUSE OF DEATH                  [Handwritten: <i>Heart Disease</i>]</p>	
<p>11. DATE OF DEATH                  [Handwritten: <i>Dec 10, 1956</i>]</p>		<p>12. TIME OF DEATH                  [Handwritten: <i>10:30 AM</i>]</p>	
<p>13. SIGNATURE OF DECEASED                  [Handwritten: <i>John Doe</i>]</p>		<p>14. SIGNATURE OF WITNESS                  [Handwritten: <i>Jane Doe</i>]</p>	
<p>15. SIGNATURE OF PHYSICIAN                  [Handwritten: <i>Dr. Smith</i>]</p>		<p>16. SIGNATURE OF CORONER                  [Handwritten: <i>John Doe</i>]</p>	

BUREAU V. S.

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14, Film G199 6-22-56 et

Dr Willson

CERTIFICATE OF DEATH

06615

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 Yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>819 Mulberry Ave</u>		d. STREET ADDRESS <u>819 Mulberry Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>AGNES</u> Last <u>PIPER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feby 30 1890</u>
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Burlington N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Augustas A. Tower</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>G. LeRoy Piper</u>		Address <u>819 Mulberry Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>o. ft.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1950</u> , to <u>13 June, 1956</u> , that I last saw the deceased alive on <u>6 June, 1956</u> , and that death occurred at <u>6:30 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>135 N. Petowee St. Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>J. D. WILSON</u>		DATE SIGNED <u>6/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

302

6622

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>				c. LENGTH OF STAY IN 1b <u>30 HRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>81 WASH. CO. HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA FLORENCE POFFENBERGER</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 11 - 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY - 6 - 1875</u> 81-55 yrs.	
9. AGE (In years last birthday)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HORSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>FRED. CO. MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HEZEKIAH CLINE</u>		14. MOTHER'S MAIDEN NAME <u>BARBARA MARKER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>101015</u>		17. INFORMANT <u>MRS. H. P. STINE</u> Address <u>SHARPSBURG MD. 1.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive - Arteriosclerotic Heart Dis.</u> DUE TO (c) <u>Unknown</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>5/3, 1956</u> , to <u>6/11, 1956</u> , that I last saw the deceased alive on <u>6/11, 1956</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lou H. H. Baker</u> M.D.				ADDRESS (Street, city or town, state) <u>174 W. Washington St.</u> DATE SIGNED <u>6/11/56</u>			
PHYSICIAN'S NAME (Type) <u>Hagerstown - Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE - 14 - 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>SHARPSBURG WASH. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u>				ADDRESS <u>BOONSBORO MD.</u>		24. REC'D BY REGISTRAR <u>June 16 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Shasth Bowers</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

9561 61 NAM

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6623  
CERTIFICATE OF DEATH

66617

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>1 Hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>	
		d. STREET ADDRESS <b>229 S. Vermont Street</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RALPH LEROY POFFENBERGER</b>		4. DATE OF DEATH Month Day Year <b>June 6 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1908</b>
9. AGE (In years last birthday) <b>47</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>13</b> Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tank Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Iron Works</b>	
11. BIRTHPLACE (State or foreign country) <b>Williamsport, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Poffenberger</b>		14. MOTHER'S MAIDEN NAME <b>Laura Nave</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-01-9892</b>	
17. INFORMANT <b>Mrs. Ralph Poffenberger - Same as above</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> ✓ DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/6/56</b> 19 to <b>6/6/56</b> 19, that I last saw the deceased alive on <b>6/6/56</b> 19, and that death occurred at <b>10:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Boyd H. Young</b> M.D.		DATE SIGNED <b>June 9, 1956</b>	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 9, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. Wolf</b>		24. REGISTRAR'S SIGNATURE <b>W. H. H. Powers</b>	

RECEIVED

BUREAU V. S.

ST-107 - Box 100, Station (of ship) - 1st & 2nd floors

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6624 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06618

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Washington</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 W. Franklin St.</u>				d. STREET ADDRESS <u>70 W. Franklin St.</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>George</u> <span style="margin-left: 50px;">First</span> <u>Emanuel</u> <span style="margin-left: 50px;">Middle</span> <u>Rider</u> <span style="margin-left: 50px;">Last</span>				<b>4. DATE OF DEATH</b> <u>June</u> <span style="margin-left: 50px;">Month</span> <u>22</u> <span style="margin-left: 50px;">Day</span> <u>1956</u> <span style="margin-left: 50px;">Year</span>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Jan 24, 1905</u>		<b>9. AGE</b> (In years last birthday) <u>51</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Cutter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Meat</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Hagerstown</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13. FATHER'S NAME</b> <u>George Rider</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Bessie Boward</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>214-09-6556</u>		<b>17. INFORMANT</b> <u>Mrs. Gertrude E. Orcutt</u> <span style="float: right;">Address <u>Hagerstown Md.</u></span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>NONE</u> 19 <u>56</u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>none</u>			
<b>20f. (City or town)</b> <u>Hagerstown</u>		<b>(County)</b> <u>Washington</u>		<b>(State)</b> <u>Md.</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>S. Robert Wells</u>		<b>EXAMINER'S NAME (Type)</b> <u>S. Robert Wells, M.D.</u>		<b>DATE SIGNED</b> <u>6-22-56</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6-25-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Rose Hill Cemetery</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>Hagerstown Md.</u>		<b>(State)</b> <u>Md.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Scott F. Minnich &amp; Son</u>			<b>ADDRESS</b> <u>Hagerstown Md.</u>				
<b>24a. REC'D BY REGISTRAR</b> <u>June 26 1956</u>			<b>24b. REGISTRAR'S SIGNATURE</b> <u>W. H. Bowers</u>				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
 PHYSICIAN'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
George Washington		1825		Male		White		Jan 24, 1956		Washington, D.C.	
Name of Informant		Relationship		Occupation		Address		City		State	
George Washington		Son		Student		1234 Main St.		Washington		D.C.	
Signature of Physician		Name of Physician		Address of Physician		City		State		Zip	
[Signature]		George Washington		1234 Main St.		Washington		D.C.		20001	

Cause of Death		Manner of Death		Place of Burial		Date of Burial		Name of Burial Place		City		State		Zip	
Heart Disease		Natural		Catholic		Jan 25, 1956		St. Mary's		Washington		D.C.		20001	
Signature of Informant		Name of Informant		Address of Informant		City		State		Zip		Signature of Physician		Name of Physician	
[Signature]		George Washington		1234 Main St.		Washington		D.C.		20001		[Signature]		George Washington	

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BUREAU V. 5

JUN 28 1956

6-2-56

George Washington

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6625

## CERTIFICATE OF DEATH

Reg. Dist. No.

06612

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				d. STREET ADDRESS <b>1116 FAIRVIEW RD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>MICHELE</b>		Middle <b>KIM</b>		Last <b>RIDGELY</b>	
4. DATE OF DEATH		Month <b>JUNE</b>		Day <b>8</b>		Year <b>19 56</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/7/56</b>		9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>INFANT</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MYRON H. RIDGELY</b>				14. MOTHER'S MAIDEN NAME <b>JOYCE SILVERNAIL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MR. MYRON H. RIDGELY</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atelectasis, lobula</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>birth</u> , 19 <u>  </u> , to <u>death</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>6-8-56</u> , 19 <u>  </u> , and that death occurred at <u>7-45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Robert F. Keadle</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Robert F. Keadle, M. D.</b>				<b>Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/9/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 11, 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Coward</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V. S.

JUN 13 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6640 CERTIFICATE OF DEATH

07655

Reg. Dist. No. 303

1. PLACE OF DEATH o. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilson Md.</b>				c. LENGTH OF STAY IN 1b <b>3 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Convalescent Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport Maryland RFD #1</b>			
				d. STREET ADDRESS <b>Williamsport Md. RFD #1</b>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Martin</b> Last <b>Roof</b>				4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1956</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18 1883</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tenant Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Franklin Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Roof</b>				14. MOTHER'S MAIDEN NAME <b>Josephine P. Faughwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-03-0090</b>		17. INFORMANT <b>Mrs. Emma Foof 210 S. Artizan St. Williamsport Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO <b></b> (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>Yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-20-56</b> 19 <b>56</b> , to <b>June 30</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>June 20</b> , 19 <b>56</b> , and that death occurred at <b>5:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, State) <b>Louis S. July 11 9 E. Choptank</b> DATE SIGNED <b>7/2/56</b>							
ACTUAL SIGNATURE <b>Louis S. July</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Louis S. July</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Boonesboro Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Boonesboro Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edith V. Leaf</b>				23b. REC'D BY REGISTRAR <b>July 5-56</b>		24b. REGISTRAR'S SIGNATURE <b>Larry M. Fickler</b>	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Color		Religion		Marital Status		Date of Birth		Date of Death		Place of Birth		Place of Death		Cause of Death		Manner of Death		Signature of Registrar		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Funeral Director		Signature of Burial Director		Signature of Cemetery Director		Signature of Undertaker		Signature of Embalmer		Signature of Crematorium Director		Signature of Other	
William Joseph		40		Male		White		White		Catholic		Single		August 18 1883		August 18 1923		Boston, Mass.		Boston, Mass.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]			

BUREAU V. R.

JUL 11 1956

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MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
 JUL 11 1956  
 [Handwritten notes and signatures]

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6626 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

66620

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <div style="text-align: right;">MARYLAND</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Winfield</b> Last <b>Sheets</b>		4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 8, 1905</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chain Grocery-A &amp; P. Chambersburg, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Sheets</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Arbaugh</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-09-345</b>	
17. INFORMANT <b>Mildred G. Sheets- 1908 Penna Ave- Hagerstown,</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of Liver, hemorrhage &amp; shock</b>  DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  DUE TO (b)  DUE TO (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b></p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto went over embankment throwing driver out of car</b>	
20c. TIME OF INJURY Hour <b>1:15</b> o. m. <b>xxxx</b> Month, Day, Year <b>May 29 1956</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural - Shepherdstown W. Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		DATE SIGNED <b>6-2-56</b>	
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/4/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Norment, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 14, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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1956 8 JUN

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JUN 8 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6627  
CERTIFICATE OF DEATH

06621

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				d. STREET ADDRESS <b>411 Mitchell Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Sours</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>19 56</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 18, 1886</b>	
9. AGE (In years lost birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Clear Spring, Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John Higgs</b>				14. MOTHER'S MAIDEN NAME <b>Florence Ditto</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT Address <b>Mrs. Thelma Deavers, Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma - entry abdominal</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <b>3 mos +</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>15 Nov</b> , 19 <b>56</b> , to <b>12 Jan</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12 Jan</b> , 19 <b>56</b> , and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>F. F. Lusby</b> ADDRESS (Street, city or town, state) <b>2307 Poloma</b> DATE SIGNED <b>13 Jan 56</b> PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b> M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-15-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				24. REC'D BY REGISTRAR <b>June 15 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Blair Bowers</b>	

BUREAU V. S.

JUN 18 1956

RECEIVED

Dr. Earl Ypung 6628

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1018 Potomac Ave.</u>				d. STREET ADDRESS <u>1018 Potomac Ave.</u>			
3. NAME OF DECEASED (Type or print) <u>BESSIE</u> <u>MAE</u> <u>SPONSELLER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7, 1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Gettysburg, Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Mathias Bupp</u>				14. MOTHER'S MAIDEN NAME <u>Jane Wentz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>17-10-3232A</u>		17. INFORMANT <u>Lloyd A. Sponseller</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO <u>Coronary Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u> <u>5 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1950</u> , 19 <u>  </u> , to <u>6/12/56</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>6.10.56</u> , 19 <u>  </u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>				DATE SIGNED <u>6/12/56</u>			
ACTUAL SIGNATURE <u>Earl Young</u>				M.D. <u>Hagerstown, Md</u>			
PHYSICIAN'S NAME (Type) <u>EARL YOUNG MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				ADDRESS <u>June 14, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 18 1956  
BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No. 314

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KEEDYSVILLE MD. R.I.</u>				d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDDIE AMBROSIE STILL</u>				4. DATE OF DEATH Month Day Year <u>JUNE - 13 - 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL - 23 - 1956</u>	9. AGE (In years last birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>20</u>	IF UNDER 24 HRS. Hours <u>20</u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KEEDYSVILLE MD. R.I.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES STILL</u>				14. MOTHER'S MAIDEN NAME <u>Doris Mills</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHARLES STILL</u> Address <u>KEEDYSVILLE MD. R.I.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> DUE TO <u>Underweight</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. <u>Secondary Anemia</u> (b) <u></u> DUE TO <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/13</u> 19 <u>56</u> to <u>6/13</u> 19 <u>56</u> , that I last saw the deceased alive on <u>6/13</u> 19 <u>56</u> , and that death occurred at <u>4:15 PM</u> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <u>W. 6/13/56</u>			
ACTUAL SIGNATURE <u>J. H. Beasley</u> M.D.				DATE SIGNED <u>6/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 15 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. BRIER CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. Co. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BAST FUNERAL HOME</u> ADDRESS <u>BOONSBORO MD</u>				24a. REC'D BY REGISTRAR <u>6/18/56</u>		24b. REGISTRAR'S SIGNATURE <u>108</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BATHING 10

BUREAU V. S.

JUN 19 1936

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 66624**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 802

**6642**

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <span style="float:right">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Hagerstown</u>			c. LENGTH OF STAY IN 1b ---	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R # 4 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Enroute to Washington Co. Hospital</u>				d. STREET ADDRESS <u>Cedar Lawn</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Edward</u> Last <u>Turner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1934</u>		9. AGE (In years last birthday) <u>21</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brakeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. M. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James R. Turner</u>				14. MOTHER'S MAIDEN NAME <u>Nettie E. Renner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>Korean</u>		16. SOCIAL SECURITY NO. <u>230--28-2964</u>		17. INFORMANT <u>Mr. James R. Turner - Cedar Lawn - Hag. Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile - Head-on Collision</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>12:30p</u> o. m. <u>xx</u> <u>June 12 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Sharpsburg Pike- Wash., Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. W. Ditto, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. W. Ditto, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown, Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman- Hagerstown, Maryland</u>				24a. REC'D BY REGISTRAR <u>June 14, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 will be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06625

6629

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Exact location not known</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Homewood Church Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Annie M. Wareheim</u>				4. DATE OF DEATH Month Day Year <u>June 14 1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 18, 1874</u>		9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>5 26</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Carroll County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Frederick Flickinger</u>				14. MOTHER'S MAIDEN NAME <u>Deborah Winters</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Rev. Mary Wagner Hagerstown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Vascular Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. j. p. m. _____ Month, Day, Year _____ <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-36</u> , 19 <u>36</u> , to <u>6-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6-12-56</u> , and that death occurred at <u>1:00</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>N. P. W. Smith</u>		M.D. <u>Hagerstown, Md</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>		DATE SIGNED <u>6/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Dr. E. W. H. H. H.</u>		M.D. <u>Hagerstown, Md</u>		ADDRESS (Street, city or town, state) <u>Hagerstown, Md</u>		DATE SIGNED <u>6/14/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/16/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Matthews Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pleasant Valley, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Rouse</u>				ADDRESS <u>Hagerstown, Maryland</u>		24. REC'D BY REGISTRAR <u>June 14, 1956</u>	
25. REGISTRAR'S SIGNATURE <u>Shash Bowers</u>				ADDRESS <u>Hagerstown, Maryland</u>		26. REGISTRAR'S SIGNATURE <u>Shash Bowers</u>	

CERTIFICATE OF DEATH

1956

NAME OF DECEASED [Faint text]		SEX [Faint text]	
DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]	
DATE OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
TIME OF DEATH [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]	
RELIGION [Faint text]		MARITAL STATUS [Faint text]	
SOCIAL SECURITY NUMBER [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]	
SIGNATURE OF CORONER [Faint text]		SIGNATURE OF JUDGE [Faint text]	

BUREAU V. S.

JUN 18 1956

RECEIVED



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6643

CERTIFICATE OF DEATH

06626

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Roanoke</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>20 East Poplar Street</u>		d. STREET ADDRESS <u>81 1/2 Street N. E.</u>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>HENRY</u> Last <u>WHITLOCK</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 25, 1855</u>
9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>1</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wheel Gang Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Norfolk Western R.R.</u>	
11. BIRTHPLACE (State or foreign country) <u>Floyd County, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel H. Whitlock</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Spangler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. L. R. Iseminger</u>		Address <u>Funkstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Generalized Arterio-sclerosis</u> <u>422.1</u> DUE TO <u>with myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 1</u> , 19 <u>56</u> , to <u>26 June</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>25 June</u> , 19 <u>56</u> , and that death occurred at <u>6:50 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. F. Lusby</u>		ADDRESS (Street, city or town, state) <u>230 N. Potomac</u>	
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>		DATE SIGNED <u>27 June 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Roanoke, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Franklin Rizer</u>		ADDRESS <u>Hagerstown, Maryland</u>	
24a. REC'D BY REGISTRAR <u>June 28, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and any event within 72 hours after death.

• *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue and red regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH. It is found in the thylakoid membranes of chloroplasts.

1

410

*(continued)*

BUREAU V.

2 JUL 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

6644

CERTIFICATE OF DEATH

Reg. Dist. No.

303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Rural</b>		c. LENGTH OF STAY IN 1b <b>3½ mos.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		d. STREET ADDRESS <b>Antietam Drive</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Wiley</b> Last <b>Wiley</b>		4. DATE OF DEATH Month <b>6</b> Day <b>2</b> Year <b>1956</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 17, 1876</b>
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>home duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Clearspring, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Wiley</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Bowers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Clarence W. Wiley</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>Cerebral Hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>several months</b> <b>4 mo.</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 23rd., 1956</b> , to <b>June 2nd., 1956</b> , that I last saw the deceased alive on <b>May 15th., 1956</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		ADDRESS (Street, city or town, state) <b>159 W. Washington St., Hagerstown, Md.</b>	
DATE SIGNED <b>6/4/56</b>			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>		<b>159 W. Washington St., Hagerstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-4-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, rural Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 6/6/56</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fickler</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		DATE OF DEATH JUN 11 1956	
AGE 45		SEX M	
RACE W		MARITAL STATUS M	
BIRTH DATE JUN 11 1911		BIRTH PLACE BALTIMORE, MD	
DECEASED'S ADDRESS 1234 E. BALTIMORE AVE BALTIMORE, MD		DECEASED'S OCCUPATION LABORER	
DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL	
DECEASED'S MANNER OF DEATH NATURAL		DECEASED'S CAUSE OF DEATH HEART DISEASE	
DECEASED'S PLACE OF DEATH HOME		DECEASED'S TIME OF DEATH 10:00 AM	
DECEASED'S SIGNATURE JAMES H. HARRIS		DECEASED'S ADDRESS 1234 E. BALTIMORE AVE BALTIMORE, MD	
DECEASED'S RELIGION METHODIST		DECEASED'S EDUCATION HIGH SCHOOL	
DECEASED'S MANNER OF DEATH NATURAL		DECEASED'S CAUSE OF DEATH HEART DISEASE	
DECEASED'S PLACE OF DEATH HOME		DECEASED'S TIME OF DEATH 10:00 AM	
DECEASED'S SIGNATURE JAMES H. HARRIS		DECEASED'S ADDRESS 1234 E. BALTIMORE AVE BALTIMORE, MD	

BUREAU V. S.

JUN 11 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

66628

Dr. Ditto

6645

## CERTIFICATE OF DEATH

Reg. Dist. No. 3022

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown R#4</u>				c. LENGTH OF STAY IN 1b <u>8 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Broadfording</u>				d. STREET ADDRESS <u>Broadfording</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>ISRAEL</u> Last <u>WOLFORD</u>				4. DATE OF DEATH Month <u>June</u> Day <u>13</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 31, 1886</u>	
9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md. R#4</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Newton Wolford</u>				14. MOTHER'S MAIDEN NAME <u>Martha Benneran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mrs. Beda Wolford-Hag. R#4</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002 X</u> DUE TO <u>Pulmonary T. B.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> DUE TO <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>18 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>  </u>				20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>11-1-53</u> , to <u>6-13-56</u> , that I last saw the deceased alive on <u>6-11-56</u> , 19 <u>  </u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. J. W. Smith</u>				ADDRESS (Street, city or town, state) <u>Hagerstown Md 9/13/56</u>			
PHYSICIAN'S NAME (Type) <u>Andrew K. Coffman</u>				DATE SIGNED <u>9/13/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-16-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Church of God Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Broadfording, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman-Hagerstown, Maryland</u>				24. REC'D BY REGISTRAR <u>June 16, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>phaser/300000</u>	



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U. S. BUREAU

1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6630

CERTIFICATE OF DEATH

66629

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Md.</b>				c. LENGTH OF STAY IN 1b <b>7 mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1720 York Rd.</b>				d. STREET ADDRESS <b>1720 York Rd.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Joseph Elmer Zimmerman</b>				4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1956</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 7, 1863</b>	
9. AGE (In years last birthday) <b>93</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Rowe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>Mrs. Charlotte Eberly Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 6-10-56</b> , 19 <b>56</b> , to <b>June 10, 1956</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>6-10-56</b> , 19 <b>56</b> , and that death occurred at <b>10:45</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Paul Harrison</b>				ADDRESS (Street, city or town, state) <b>318 N. Potomac St., Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Paul Harrison</b>				DATE SIGNED <b>6-11-56</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/13/1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>		22d. LOCATION (City, town, or county) (State) <b>Emmitsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>				ADDRESS <b>Emmitsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 6-13-56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. Bowers</b>			

